STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	009443	A. BUILDING: _____ B. WING _____	01/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL-EVANSVILLE	400 SE 4TH ST EVANSVILLE, IN 47713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 01-27-14 Facility number: 009443 Complaint number: IN00131987 Unsubstantiated; Lack of sufficient evidence Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Select Specialty Hospital-Evansville is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-2, Infection control, Hospital Licensure Rules. QA: claughlin 02/10/14	S 000		